County of Los Angeles
DEPARTMENT OF CHILDREN AND FAMILY SERVICES

425 Shatto Place, Los Angeles, California 90020
(213) 351-5602

PHILIP L. BROWNING
Director

November 16, 2012

To: Supervisor Zev Yaroslavsky, Chairman
Supervisor Gloria Molina
Supervisor Mark Ridley-Thomas
Supervisor Don Knabe
Supervisor Michael D. Antonovich

From: Philip L. Browning
Director

PERFECT IMAGE YOUTH CENTER CONTRACT COMPLIANCE MONITORING REVIEW

The Los Angeles County Department Children and Family Services (DCFS) Out-of-Home Care Management Division (OHCMD) conducted a review of Perfect Image Youth Center (Perfect Image) Group Home (GH) in June 2012, at which time they had one six-bed site and five female DCFS placed children.

Perfect Image is located in Riverside County and provides services to DCFS foster youth. According to Perfect Image's program statement, its stated goal is "to provide a comprehensive array of services in an environment that the youth will experience as being safe, protective, nurturing, appropriately structured, and responsive to their individual needs." Perfect Image is licensed to serve a capacity of six female children, ages 13 through 17.

For the purpose of this review, two placed children were interviewed as the other three children had been placed less than 30 days, and their case files were reviewed. The placed children's average length of placement was six months and the average age was 16. Five discharged children's case files were reviewed to determine if the destination of placement was per their permanency plan and if the children were meeting their Needs and Services Plan (NSP) goals at time of discharge. Three staff files were reviewed for compliance with Title 22 Regulations and the County contract requirements.

One sampled child was prescribed psychotropic medication. We reviewed the case file to assess timeliness of the Psychotropic Medication Authorization (PMA) and to confirm documentation of psychiatric monitoring was maintained as required.

SCOPE OF REVIEW

The purpose of this review was to assess Perfect Image's compliance with the County contract requirements and State regulations. The visit included a review of Perfect Image's program statement, administrative internal policies, two current children's case files, five discharged children's case files, and a random sampling of personnel files. A visit was made to the facility to assess the quality of care and supervision provided to children, and we conducted interviews with children to assess the care and services they were receiving.

A copy of this report has been sent to the Auditor-Controller (A-C) and Community Care Licensing (CCL).

SUMMARY

During our review, the interviewed children reported eating good food, feeling safe and being treated with respect and dignity by staff members.

At the time of the review, Perfect Image needed to address physical plant deficiencies, a few of which needed to be corrected immediately. Specifically, there was an exposed wire in the kitchen and inoperable smoke detectors in the kitchen and hallway. Perfect Image needed to ensure children were receiving the required therapeutic services, specifically weekly in-house group therapy. In addition, Perfect Image needed to ensure development of comprehensive NSPs; needed to ensure DCFS Children's Social Workers' (CSWs) authorizations to implement the NSPs were documented; and that the children's PMAs were current and consistent with their prescribed psychotropic medications. Additionally, Perfect Image needed to encourage and assist children in creating and maintaining a Photo Album/Life Book; ensure all staff members receive initial training as required in accordance with Title 22 regulations and the Perfect Image program statement related to Job Shadowing, as well as ensure timely certification of staff in CPR, First-Aid and the Emergency Intervention Plan.

Perfect Image's Executive Director was receptive to implementing systemic changes to improve compliance with the regulations and the County contract requirements. The Executive Director agreed to address the deficiencies in a Corrective Action Plan (CAP).

We noted that Perfect Image implemented three of 10 recommendations from the prior review. Furthermore, we noted an additional 21 recommendations during this review. The significant number of findings and failure to fully implement 70% of their CAP from the prior review is of concern and leads OHCMD to question Perfect Image's ability to

maintain appropriate service delivery to our placed children; and therefore, Perfect Image GH was placed on a Hold-status.

NOTABLE FINDINGS

The following were the notable findings of our review:

- All Special Incident Reports (SIRs) were not adequately documented and/or cross-reported to all applicable parties in accordance with the County contract Exhibit A-VIII, Special Incident Reporting Guide For Group Homes. Specifically, OHCMD requested a CAP for two SIRs that were inadequately documented and noted that some SIRs were not cross-reported to all applicable parties. The Executive Director acknowledged the deficiency and stated that Exhibit A-VIII is posted in the staff office and that Perfect Image will ensure staff members review the policy again. It was also noted that the OHCMD, Probation Department and Community Care Licensing provided Special Incident Report training in September and October 2011, and the Facility Manager and Child Care Worker/Office Support staff member attended the training in October 2011.

- The child population was not consistent with the Perfect Image GH program statement. We found that one of the two sampled youth was an adult dependent and Perfect Image did not have an age exemption from CCL, nor the roommate's CSW's written approval to share a bedroom with an adult, even though CCL, via e-mail, had advised Perfect Image of the age exemption process.

  The Executive Director stated that they had recently revised their program statement to serve AB 12 youth and were awaiting CCL's approval before submitting their program statement to Los Angeles County DCFS Contracts for review and approval. However, the Monitor pointed out that AB 12 did not apply to this particular youth, as she was placed three months prior to AB 12 being enacted, as well as the fact that Perfect Image was pending approval to serve AB 12 youth. The Executive Director had no further comment.

  We also discovered during the review that Perfect Image had recently accepted a pregnant youth, although Perfect Image's program statement clearly documents they do not accept pregnant youth. The Executive Director first stated that she thought they could accept pregnant youth up to 24 weeks of pregnancy and later stated that in retrospect, she did not believe that she was aware of the child's pregnancy prior to her admission. However, the Monitor requested the child's "Foster Child's Needs and Case Plan Summary" (DCFS 709), which documented the child's pregnancy. Subsequently, the Monitor requested Perfect Image contact the child's CSW and request an expedited Resource Management Process (RMP). The Monitor also contacted the CSW and discussed placement resources, as well as alerting Resource Utilization Management (RUM) of the situation. The child was subsequently replaced.

- A deficiency was noted regarding maintenance of documentation. Regulations state children are to sign for disbursements of clothing allowances. Perfect Image did not have a clothing allowance log for this child, and there was no documentation that the clothing allowance had been issued to the child. According to the Executive Director, the child chose to defer their monthly clothing allowance to the following month in order to purchase more costly items, and it had not been documented in the clothing allowance log. The Executive Director acknowledged the error and stated they will have the child sign and date a clothing allowance agreement letter, with the information reflected in the clothing allowance log.

- CCL had cited Perfect Image as a result of deficiencies and findings identified during three CCL investigations. On March 9, 2011, CCL cited Perfect Image for a substantiated allegation of Personal Rights Violation as Perfect Image did not provide medical treatment to a foster child. CCL concluded the following: Personnel Duties as staff failed to provide adequate medical care and supervision for the child allowing the child to go the hospital emergency room alone without supervision; Night Supervision as Perfect Image failed to have an on-call person available to assist with an emergency situation; Personal Rights as Perfect Image failed to call 911 or take the child to the hospital emergency room. Perfect Image was requested to provide a Plan of Correction (POC), which included providing training to staff in protocol when a child is in urgent need/distress and develop an on-call staff roster. CCL provided a Letter of Deficiency Citations Cleared on May 10, 2011.

  On March 28, 2011, CCL cited Perfect Image for a substantiated allegation of Personal Rights. CCL concluded that two staff members interacted inappropriately with children by yelling and making disparaging remarks. Perfect Image was requested to provide a POC, which included providing training to staff in Client's Rights and an appropriate approach with clients in care and co-workers. CCL provided a Letter of Deficiency Citations Cleared on March 29, 2011.

  On July 26, 2011, CCL cited Perfect Image for a substantiated allegation of Building and Grounds violations. On July 18, 2011 and July 26, 2011, the Licensing Program Analyst observed the kitchen oven to be non-functioning and carpeting throughout the group home to be dirty. Perfect Image was requested to provide a POC, which included repairing the oven and cleaning the carpet. CCL provided a Letter of Deficiency Citations Cleared on August 15, 2011. The Executive Director reported that they had resolved the above issues and received clearance by CCL.

- Although Perfect Image maintains a Sign In/Out Log, it was not properly maintained in that the log did not include all required elements, including the destination of the child, the anticipated time of child's return and the telephone number of the person who is responsible for the child. The Executive Director reported that they will revise the log and the staff members will ensure the log is consistently completed.

- Multiple deficiencies were noted in the common areas. Specifically, the kitchen and hallway smoke detectors were inoperable. The Executive Director reported that she replaced the batteries in the two smoke detectors that day. Furthermore, the CCL Licensing Program Analyst conducted a random, unannounced Annual Review on August 24, 2012, and verified that the smoke detectors were operable. In addition, the kitchen wall had an exposed wire, which was subsequently confirmed by the Monitor to be repaired. The recreation room carpet had a throw rug, which concealed a torn and soiled area of the wall-to-wall carpet. The Executive Director stated that the recreation room carpet would be replaced. The common bathroom floor behind the toilet needed repair. The Executive Director stated it would be repaired. The second bathroom light fixture contained uncovered light bulbs. The Executive Director stated that the GH maintenance man will determine if the light bar will be repaired or replaced. The hallway closet containing the air-conditioning/heating unit was not locked. The Executive Director reported that the maintenance man will put a lock on the hallway closet door. Subsequently, Perfect Image e-mailed photographs showing that the recreation room carpet and the bathroom floor had been repaired, the bathroom light fixture had been replaced, and the hallway closet containing the air-conditioning/heating unit contained a lock.

  Generally, the interior needed cleaning to eradicate cobwebs, dirt-filled window sills and vents, as well as dirty woodwork molding. The Executive Director acknowledged all of the deficiencies. She reported that the GH is located in a rural area where there is an abundance of dirt and will implement a daily cleaning list for every staff member to complete during their shift. She also stated that although the GH has a board posted for all staff members to report physical plant issues to the maintenance man, a staff member will accompany the maintenance man on a weekly walk-through to ensure the GH is well maintained.

- Multiple deficiencies were noted in the children's bedrooms. All three bedrooms had insufficient lighting. The Executive Director stated that the bedroom lamps contained energy-efficient light bulbs that become brighter as they remain on, but stated that additional lighting will be added in each bedroom. Subsequently, the group home e-mailed photographs of an additional lamp in each bedroom. In addition, bedrooms one, two and three contained dressers with drawers that were off the track and therefore not useable. Bedroom three contained a dresser with a broken back side, which contained exposed staples with a chipped and splintered veneer. The Monitor requested the immediate repair or removal of the dresser; the dresser was immediately repaired to remove any safety risk to the children. The closet in bedroom two had a patched area that needed to be painted, which the Monitor later observed to be repaired. The Executive Director and Facility Manager stated that the dressers are new, but the children overfill the drawers, which leads to the drawers coming off the track. They stated they will have the maintenance man put the drawers back on the tracks.

- The exterior was not well maintained as both the front and back yard contained dead grass and dirt. In addition, the outdoor area did not contain any recreational equipment or seating for the children. The Executive Director stated that it has been an on-going issue with the landlord refusing to assist with the lawn and sprinklers, as the landlord advised them that since the house is used to run a business, the lawn is the group home's responsibility. Although this has been an on-going issue, the Executive Director stated that she recently left the landlord a message requesting assistance with the yard. The Facility Manager further stated that they employ a twice-a-month lawn service to keep the weeds away. She also stated that although the children do not like to go outdoors, she will purchase outdoor recreation equipment and chairs for the children. The Facility Manager stated that they have created a recreational equipment inventory list to track the inventory and its condition. Subsequently, Perfect Image e-mailed photographs of six fold-up chairs for outdoor seating and the recreational equipment.

- The initial and updated NSPs were not comprehensive, did not have the DCFS CSWs' authorizations for implementation and did not contain monthly contacts by the GH and CSWs. Furthermore, the Executive Director acknowledged that they had failed to obtain CSWs' signatures authorizing NSPs and would now fax and/or e-mail NSPs to the CSWs and attach the documentation to the NSP. The Executive Director acknowledged the NSP deficiencies and requested the GH Therapist to attend a NSP training the following day with the Monitor. On June 19, 2012, the Monitor provided additional NSP training to the GH Therapist. Additionally, OHCMD re-sent Perfect Image the NSP training presentation material for added support. It was also noted that only a Child Care Worker had attended the NSP training provided by OHCMD and Probation Department in January 2012. The GH Therapist reported that she had not been informed of the NSP training.

- The children were not receiving the required therapeutic services of weekly in-house group therapy, per the GH program statement. The GH Therapist stated that she had not been providing group therapy due to the transitory population. The Executive Director stated that the therapist should have been providing weekly group therapy and will ensure the children receive weekly in-house group therapy.

- One child's PMA was not consistent with the child's prescribed psychotropic medication, nor did the child receive a current psychiatric evaluation/review. The Executive Director/Administrator and Child Care Worker reported that the child was placed to the home on April 15, 2012, with a current PMA, did not see the psychiatrist in May 2012, and was on an out-of-state two-week visit in June 2012. The Child Care Worker reported that the child was evaluated by a psychiatrist on July 3, 2012, and later provided the documentation. We found that the Psychotropic Medication Authorization (PMA) was not consistent with the psychotropic medication the child was administered and documented in the Medication Log. Specifically, the child was receiving Seroquel, however it was not included in the PMA. In addition, the child did not have a current psychiatric evaluation/review.

According to the Psychological/Other Examination Form, dated July 3, 2012, the child's Seroquel was discontinued, making the current approved PMA consistent with the child's prescribed psychotropic medication. The Executive Director stated that in the future, the child's PMA and Medication Log will be reviewed by the Executive Director and Facility Manager on a daily and weekly basis to ensure the child's prescribed psychotropic medication is consistent with their PMA. In addition, the Executive Director stated that in order to ensure children on psychotropic medication receive a monthly psychiatric evaluation/review, the Facility Manager will review children's files on a monthly basis to ensure children have a monthly psychiatric appointment.

- A deficiency was noted in the area of ensuring personal needs/survival and economic well-being of placed children. The same child as noted above had not received the required monthly $50 clothing allowance. The Executive Director stated that the child wanted to defer the clothing allowance to the following month in order to purchase more costly items. She acknowledged, however, that this information was not documented in the clothing allowance log. The Executive Director stated that in the future, when a child wishes to defer the clothing allowance, they will have the child sign and date a clothing allowance agreement letter and the information will also be reflected in the clothing allowance log.

- Two children interviewed were not encouraged and assisted in creating and updating a Life Book/Photo Album; neither child had any knowledge of a scrapbook or Life Book/Photo Album. The Child Care Worker stated they had taken pictures of the children during outings and photos were saved in the office computer. The Executive Director stated that in the future, the pictures will be downloaded, printed and given to the children. Group meetings will also be conducted in order to assist the children with assembling their Life Book/Photo Albums.

- Two of the three reviewed staff members did not have documentation of timely criminal clearances; one staff did not complete a criminal background statement; two staff did not receive and/or have documentation of timely initial health screenings; three staff files did not contain signed copies of the group home's policies and procedures; three staff members did not receive the required initial training in that one staff file did not have documentation of the initial training and two staff members' files did not include documentation that they had received Job Shadow training. One staff member did not receive timely certification in CPR and First Aid; and two staff did not receive timely certification in the Emergency Intervention Plan. The Executive Director reported that the Facility Manager received a timely criminal clearance, as she was hired when the GH was licensed and could not have been licensed without the staff member being criminally cleared. The Monitor suggested they obtain from CCL documentation of the staff's initial criminal clearance date and place the documents in the file. The Executive Director stated that a designated staff member will be assigned to review staff files on a monthly basis to ensure full compliance with all regulatory agencies.

The detailed report of our findings is attached.

EXIT CONFERENCE

The following are highlights from the Exit Conference held July 19, 2012:

In attendance:

Sandra Cromer, Executive Director; Pauleena Parra, Child Care Worker, Perfect Image Youth Center; and Kristine Kropke Gay, Monitor, DCFS OHCMD.

Highlights:

The Executive Director was in agreement with most of our findings and recommendations and agreed to provide a CAP to address each deficiency.

Perfect Image submitted an approved CAP addressing each recommendation noted in this compliance report.

We will assess for full implementation of recommendations during our next monitoring review.

If you have any questions, please call me or your staff may contact Aldo Marin, Board Relations Manager, at (213) 351-5530.

PLB:RRS:KR
EAH:PBG:kkg

Attachments

c: William T Fujioka, Chief Executive Officer
Wendy Watanabe, Auditor-Controller
Jerry E. Powers, Chief Probation Officer
Public Information Office
Audit Committee
Sybil Brand Commission
Bobby Turner, President, Board of Directors, Perfect Image Youth Center
Sandra Cromer, Executive Director, Perfect Image Youth Center
Linda Calhoun, Program Manager, Community Care Licensing
Lenora Scott, Regional, Manager, Community Care Licensing
Angelica Lopez, Acting Regional Manager, Community Care Licensing
Deborah Santos, Acting Regional Manager, Community Care Licensing

PERFECT IMAGE YOUTH CENTER
CONTRACT COMPLIANCE MONITORING REVIEW SUMMARY

16761 Washington Street
Riverside, CA 92504
License Number: 336408586
Rate Classification Level: 9

	Contract Compliance Monitoring Review	Findings: June 2012
I	**Licensure/Contract Requirements** (9 Elements)	
	1. Timely Notification for Child's Relocation	1. Full Compliance
	2. Transportation	2. Full Compliance
	3. Special Incident Reports (SIRs)	3. Needs Improvement
	4. Compliance with Licensed Capacity	4. Full Compliance
	5. Disaster Drills Conducted & Logs Maintenance	5. Full Compliance
	6. Runaway Procedures	6. Full Compliance
	7. Allowance Logs	7. Needs Improvement
	8. CCL Citation/OHCMD Investigation Reports on Safety/Plant Deficiencies	8. Needs Improvement
	9. Detailed Sign In/Out Logs for Placed Children	9. Needs Improvement
II	**Facility and Environment** (6 Elements)	
	1. Exterior Well Maintained	1. Needs Improvement
	2. Common Areas Maintained	2. Needs Improvement
	3. Children's Bedrooms/Interior Maintained	3. Needs Improvement
	4. Sufficient Recreational Equipment	4. Needs Improvement
	5. Sufficient Educational Resources	5. Full Compliance
	6. Adequate Perishable and Non Perishable Food	6. Full Compliance
III	**Maintenance of Required Documentation and Service Delivery** (13 Elements)	
	1. Child Population Consistent with Program Statement	1. Needs Improvement
	2. DCFS CSW Authorization to Implement NSPs	2. Needs Improvement
	3. Children's Participation in the Development of NSPs	3. Full Compliance
	4. NSPs Implemented and Discussed with Staff	4. Full Compliance
	5. Children Progressing Toward Meeting NSP Case Goals	5. Full Compliance
	6. Development of Timely Initial NSPs	6. Full Compliance
	7. Development of Comprehensive Initial NSPs	7. Needs Improvement
	8. Therapeutic Services Received	8. Needs Improvement

	9. Recommended Assessment/Evaluations Implemented 10. DCFS CSWs Monthly Contacts Documented 11. Children Assisted in Maintaining Important Relations 12. Development of Timely Updated NSPs 13. Development of Comprehensive Initial/Updated NSPs	9. Full Compliance 10. Needs Improvement 11. Full Compliance 12. Full Compliance 13. Needs Improvement
IV	**Education and Emancipation Services** (8 Elements) 1. Children Enrolled in School Timely 2. Children Attending School 3. GH Facilitates in Meeting Child's Educational Goals 4. Children's Academic or Attendance Increase 5. Current IEPs Maintained 6. Current Report Cards Maintained 7. YDS/Vocational Programs Opportunities Provided 8. GH Encourages Children's Participation in YDS	Full Compliance (All)
V	**Health and Medical Needs** (6 Elements) 1. Initial Medical Exams Conducted 2. Initial Medical Exams Timely 3. Follow-Up Medical Exams Timely 4. Initial Dental Exams Conducted 5. Initial Dental Exams Timely 6. Follow-Up Dental Exams Timely	Full Compliance (All)
VI	**Psychotropic Medication** (2 Elements) 1. Current Court Authorization for Administration of Psychotropic Medication 2. Current Psychiatric Evaluation Review	1. Needs Improvement 2. Needs Improvement

VII	**Personal Rights and Social/Emotional Well-Being** (15 Elements) 1. Children Informed of Group Home's Policies and Procedures 2. Children Feel Safe 3. Satisfaction with Meals and Snacks 4. Staff Treatment of Children with Respect and Dignity 5. Appropriate Rewards and Discipline System 6. Fair Consequences 7. Children Allowed Private Visits, Calls, and Correspondence 8. Children Free to Attend Religious Services/Activities 9. Reasonable Chores 10. Children Informed About Their Medication 11. Children Aware of Right to Refuse Psychotropic Medication 12. Children Free to Receive or Reject Voluntary Medical, Dental, and Psychiatric Care 13. Children Given Opportunities to Plan Activities 14. Children Participate in Activities (GH, School, Community) 15. Children Given Opportunities to Participate in Extra-Curricular, Enrichment and Social Activities	Full Compliance (All)
VIII	**Personal Needs/Survival and Economic Well-Being** (8 Elements) 1. $50 Clothing Allowance 2. Adequate Quantity Clothing Inventory 3. Adequate Quality Clothing Inventory 4. Involvement in Selection of Clothing 5. Provision of Personal Care Items 6. Minimum Monetary Allowances 7. Management of Allowance/Earnings 8. Encouragement and Assistance with Life Book/Photo Album	1. Needs Improvement 2. Full Compliance 3. Full Compliance 4. Full Compliance 5. Full Compliance 6. Full Compliance 7. Full Compliance 8. Needs Improvement
IX	**Discharged Children** (3 Elements) 1. Children Discharged According to Permanency Plan 2. Children Making Progress Toward NSP Goals 3. Attempts to Stabilize Children's Placement	Full Compliance (ALL)

X	**Personnel Records** (14 Elements)	
	1. DOJ Submitted Timely	1. Needs Improvement
	2. FBI Submitted Timely	2. Needs Improvement
	3. CACIs Submitted Timely	3. Needs Improvement
	4. Criminal Background Statement Signed Timely	4. Needs Improvement
	5. Education/Experience Requirement	5. Full Compliance
	6. Employee Health Screening Timely	6. Needs Improvement
	7. Valid Driver's License	7. Full Compliance
	8. Signed Copies of GH Policies and Procedures	8. Needs Improvement
	9. Initial Training Documentation	9. Needs Improvement
	10. One-Hour Child Abuse and Reporting Training	10. Full Compliance
	11. CPR Training Documentation	11. Needs Improvement
	12. First-Aid Training Documentation	12. Needs Improvement
	13. On-going Training Documentation	13. Full Compliance
	14. Emergency Intervention Training Documentation	14. Needs Improvement

PERFECT IMAGE YOUTH CENTER
CONTRACT COMPLIANCE MONITORING REVIEW

16761 Washington Street
Riverside, California 92504
License Number: 336408586
Rate Classification Level: 9

The following report is based on a "point in time" monitoring visit and addresses findings noted during the June 2012 monitoring review.

CONTRACTUAL COMPLIANCE

Based on our review, Perfect Image Youth Center (Perfect Image) was in full compliance with four of 10 sections of our contract compliance review: Education and Workforce Readiness; Health and Medical Needs; Personal Rights and Social/Emotional Well-Being; and Discharged Children. The following report details the results of our review.

LICENSURE/CONTRACT REQUIREMENTS

Based on our review of two children's case files and/or documentation from the provider, Perfect Image fully complied with five of nine elements reviewed in the area of Licensure/Contract Requirements.

During this review period, the Out-of-Home Care Management Division (OHCMD) requested a Corrective Action Plan (CAP) for inadequately documented and/or untimely submission of Special Incident Reports (SIRs) in accordance with the County contract requirement, Special Incident Report Guide for Group Homes, Exhibit A-VIII. Additionally, OHCMD noted that some SIRs were not cross-reported to all applicable parties. The Executive Director acknowledged the deficiency and stated that Exhibit A-VIII is posted in the staff office and the group home will ensure staff members review the policy again. It was also noted that the OHCMD, Probation Department and Community Care Licensing provided Special Incident Report training in September and October 2011, and the Facility Manager and Child Care Worker/Office Support staff member attended the training in October 2011.

One reviewed child had no documentation of using the monthly clothing allowance; there was no clothing allowance log on file for this child. According to the Executive Director, the child chose to defer the monthly allowance to the following month in order to purchase more costly items and staff had not documented this in the clothing allowance log. The Executive Director acknowledged the error and stated that when a child wishes to defer the clothing allowance, they will have the child sign and date a clothing allowance agreement letter, and the information will be reflected in the clothing allowance log.

Community Care Licensing (CCL) had cited Perfect Image as a result of deficiencies and findings during three CCL investigations. On March 9, 2011, CCL cited Perfect Image for a substantiated allegation of Personal Rights Violation as Perfect Image did not provide medical treatment to a foster child. CCL concluded the following: Personnel Duties as staff failed to provide adequate medical care and supervision for the child, allowing the child to go the hospital emergency room alone and without supervision; Night Supervision as Perfect Image failed to have an on-call person available to assist with emergency situation; Personal Rights as Perfect Image failed to call 911 or to take the child to the hospital emergency room. Perfect Image was to provide a Plan of Correction (POC), which included providing training to staff in protocol when a child is in urgent need/distress; and to develop an on-call staff roster. CCL provided a Letter of Deficiency Citations Cleared on May 10, 2011.

On March 28, 2011, CCL cited Perfect Image for a substantiated allegation of Personal Rights. CCL concluded that two staff members interacted inappropriately with the children by yelling and making disparaging remarks. Perfect Image was to provide a POC, which included providing training to staff in Client's Rights and an appropriate approach with clients and co-workers. CCL provided a Letter of Deficiency Citations Cleared on March 29, 2011.

On July 26, 2011, CCL cited Perfect Image for a substantiated allegation of Building and Grounds violations. On July 18, 2011 and July 26, 2011, the Licensing Program Analyst observed the kitchen oven to be non-functioning and carpeting throughout the group home to be dirty. Perfect Image was to provide a POC, which included repairing the oven and cleaning the carpet. CCL provided a Letter of Deficiency Citations Cleared on August 15, 2011. The Executive Director reported they had resolved the above issues and received clearance by CCL.

Although Perfect Image maintains a Sign In/Out Log, it was not properly maintained in that the log did not include all required elements, including the destination of the child, the anticipated time of child's return, and the telephone number of the person who is responsible for the child. The Executive Director reported that they will revise the log and the staff members will ensure the log is consistently completed.

Recommendations:

Perfect Image's management shall ensure:

1. All SIRs are appropriately documented and cross-reported timely.

2. The Clothing Allowance Logs are thoroughly documented and maintained.

3. The group home is compliant with Title 22 Regulations and County contract requirements.

4. The group home maintains a detailed Sign-in/Out Log.

FACILITY AND ENVIRONMENT

Based on a walk-through of the facility and/or documentation from the provider, Perfect Image fully complied with two of six elements reviewed in the area of Facility and Environment.

While the group home provided a home-like setting, the interior of the group home had several issues of concern. Although all three bedrooms contained working smoke detectors, the kitchen and hallway smoke detectors were inoperable. The Executive Director reported that she replaced the batteries in the two smoke detectors that day. Furthermore, the CCL Licensing Program Analyst conducted a Random/Annual Review on August 24, 2012, and verified that the smoke detectors were operable. The kitchen wall had an exposed wire, which was subsequently confirmed by the Monitor to have been repaired. The recreation room carpet had a throw rug, which concealed a torn and soiled area of the wall-to-wall carpet. The Executive Director stated that the recreation room carpet would be replaced. The common bathroom floor behind the toilet needed repair. The Executive Director stated it would be repaired. The second bathroom light fixture contained uncovered light bulbs. The Executive Director stated that the group home maintenance man will determine if the light bar will be repaired or replaced. The hallway closet containing the air conditioning/heating unit was not locked. The Executive Director reported that the maintenance man will put a lock on the hallway closet door. Subsequently, Perfect Image e-mailed photographs showing that the recreation room carpet had been repaired, the common bathroom floor had been repaired, the second bathroom light fixture had been replaced and the hallway closet containing the air conditioning/heating unit contained a lock.

Multiple deficiencies were noted in the children's bedrooms. All three bedrooms had insufficient lighting. The Executive Director stated that the bedroom lamps contained energy-efficient light bulbs that become brighter as they remain on, but stated that additional lighting would be added in each bedroom. Subsequently, the group home e-mailed photographs of an additional lamp in each bedroom. Bedrooms one, two and three contained dressers with drawers that were off the track; the drawers could not be used. Bedroom three contained a dresser with a broken back side, which contained exposed staples with a chipped and splintered veneer. The Monitor requested the immediate repair or removal of the dresser; the dresser was immediately repaired to remove any safety risk to the children. The Executive Director and Facility Manager stated that the dressers were new, but the children overfill the drawers, which leads to the drawers coming off the track. The maintenance man put the drawers back in the tracks. Lastly, the closet in bedroom had a patched area that needed to be painted, which the Monitor later observed to have been repaired.

Generally, the interior needed cleaning to eradicate cobwebs, dirt-filled window sills and vents, as well as dirty woodwork molding. The Executive Director acknowledged all of the deficiencies. She reported that the group home is located in a rural area, where there is an abundance of dirt and she will implement a daily cleaning list for every staff

member to complete during their shift and that "in the common areas, the window sills, molding, and ceiling corners were all deep cleaned and dirt/dander has been removed." The Executive Director also stated that although the group home has a board posted for all staff members to report physical plant issues to the group home maintenance man, a staff member will now accompany the maintenance man on a weekly walk-through to ensure the group home is well maintained.

The exterior was not well maintained both the front and back yard contained dead grass and dirt. In addition, the outdoor area did not contain any recreational equipment or seating for the children. The Executive Director stated that it has been an on-going issue with the landlord refusing to assist with providing lawn and sprinklers; the landlord advised them that since the house is used to run a business, the lawn is the group home's responsibility. Although this has been an on-going issue, the Executive Director stated that she recently left the landlord a message requesting assistance with the yard. The Facility Manager further stated that they employ a twice-monthly lawn service to keep the weeds down.

Regarding recreational equipment and seating, the Executive Director stated that although the children do not like to go outdoors, she will purchase outdoor recreation equipment and chairs for the children. The Facility Manager stated they have now created a recreational equipment inventory list to track the inventory and its condition. Subsequently, Perfect Image e-mailed photographs of six fold-up chairs and recreational equipment.

Recommendations:

Perfect Image's management shall ensure:

5. The group home exterior is well maintained.

6. The group home common quarters are well maintained.

7. All bedrooms are well maintained.

8. The group home provides sufficient age-appropriate recreational equipment.

MAINTENANCE OF REQUIRED DOCUMENTATION AND SERVICE DELIVERY

Based on our review of two children's case files and/or documentation from the provider, Perfect Image fully complied with seven of 13 elements reviewed in the area of Maintenance of Required Documentation and Service Delivery.

We found the placement of children was not consistent with the Perfect Image program statement. One sampled youth was an adult dependent and did not have an age exemption from Community Care Licensing (CCL), nor the roommate's CSW's written approval to share a bedroom with an adult, even though CCL, via e-mail, had advised

Perfect Image of the age exemption process. The Executive Director stated that they had revised their program statement to serve AB 12 youth and were awaiting CCL's approval before submitting their program statement to Los Angeles County DCFS Contracts for review and approval. However, the Monitor pointed out that AB 12 did not apply to this particular youth, as she was placed three months prior to AB 12 being enacted, as well as the fact that Perfect Image was pending approval to serve AB 12 youth. The Executive Director had no further comment.

Furthermore, the Monitor contacted Perfect Image's Licensing Program Analyst (LPA) to advise the LPA of the situation. The LPA stated that CCL would not provide an age exemption for this youth, although an age-waiver was required when this youth had turned 18.

We also discovered during the review that Perfect Image had recently accepted a pregnant child, although Perfect Image's program statement clearly documents they do not accept pregnant youth. The Executive Director first stated that she thought they could accept pregnant youth up to 24 weeks of pregnancy and later stated that in retrospect, she did not believe that she was aware of the child's pregnancy prior to her admission. However, the Monitor requested the child's "Foster Child's Needs and Case Plan Summary" (DCFS 709), which documented the child's pregnancy. Subsequently, the Monitor requested Perfect Image contact the child's CSW and request an expedited Resource Management Process (RMP). The Monitor also contacted the CSW and discussed placement resources, as well as alerting Resource Utilization Management (RUM) of the situation. The child was subsequently replaced.

All reviewed NSPs were timely; however, none were comprehensive and did not meet all required elements in accordance with the NSP/Quarterly Report template. Specifically, the two initial NSPs did not contain specific or measureable treatment goals. The three updated NSP/Quarterly Reports contained inaccurate information and/or the information was insufficient and was not updated. Additionally, some NSP/Quarterly Only Report sections did not document the child's updated quarterly progress and the updated information was not always consistent with the treatment goals. Furthermore, the NSPs were not authorized by the DCFS CSWs for implementation, nor was there documentation of attempts to obtain the CSWs' signatures or documentation that the group home had monthly contacts with the CSWs.

The Monitor reviewed the NSP deficiencies with the Executive Director and a Child Care Worker. The Monitor informed them of the importance and purpose of obtaining the CSW's signature, as well as to document attempts to obtain the CSW's authorization to implement and/or modify NSPs. Additionally, the Monitor suggested timely invitations to CSWs to attend NSPs during their monthly child visits. The Executive Director acknowledged the NSP deficiencies and requested the GH Therapist to attend a NSP training the following day with the Monitor. On June 19, 2012, the Monitor provided additional NSP training to the GH Therapist, who was very receptive to participating in the training. Additionally, the OHCMD and Probation Department provided NSP training in January 2012, although only one Child Care Worker attended

the training. The GH Therapist reported that she had not been informed of the NSP training. Additionally, OHCMD re-sent Perfect Image the NSP training presentation material for added support. Furthermore, the Executive Director acknowledged they had failed to obtain CSWs' signatures authorizing NSPs and would now fax and/or e-mail NSPs to CSWs and attach the documentation to the NSP.

Additionally, although the GH was providing tri-weekly off-campus drug and alcohol group therapy, the children were not provided weekly in-house group therapy in accordance with the Perfect Image program statement. The GH Therapist stated that she had not been providing group therapy due to the transitory population. The Executive Director stated that the therapist should have been been providing weekly group therapy and will ensure the children receive weekly in-house group therapy.

Recommendations:

Perfect Image's management shall ensure:

9. Children are placed in accordance the group home's program statement.

10. Staff obtain or document efforts to obtain the DCFS CSW's authorization to implement the NSPs.

11. Initial NSPs are comprehensive.

12. Updated NSPs are comprehensive.

13. Children receive required therapeutic services.

14. Monthly contacts with DCFS CSWs are conducted and appropriately documented.

PSYCHOTROPIC MEDICATION

Based on our review of two children's files and/or documentation from the provider, Perfect Image did not comply with the two elements in the area of Psychotropic Medication.

One sampled child was prescribed psychotropic medication at the time of the review. We found that the Psychotropic Medication Authorization (PMA) was not consistent with the psychotropic medication the child was administered and documented in the Medication Log. Specifically, the child was receiving Seroquel; however, it was not included in the PMA. In addition, the child did not have a current psychiatric evaluation/review. The child was placed to the home on April 15, 2012, and was not evaluated by a psychiatrist until July 3, 2012. The Executive Director and Child Care Worker reported that the child was placed with a current PMA, did not see the psychiatrist in May 2012, and was on an out-of-state two-week visit in June 2012. According to the Psychological/Other Examination Form, dated July 3, 2012, the child's

Seroquel was discontinued, making the current approved PMA consistent with the child's prescribed psychotropic medication. The Executive Director stated that in the future, the child's PMA and Medication Log will be reviewed by the Executive Director and Facility Manager on a daily and weekly basis to ensure the child's prescribed psychotropic medication is consistent with their PMA. In addition, the Executive Director stated that in order to ensure children on psychotropic medication receive a monthly psychiatric evaluation/review, the Facility Manager will review the child's file on a monthly basis to ensure children have a monthly psychiatric appointment.

Recommendations:

Perfect Image's management shall ensure:

15. All children have a current Court-approved PMA for the administration of psychotropic medication.

16. All children have a current psychiatric evaluation for prescribed medication.

PERSONAL NEEDS/SURVIVAL AND ECONOMIC WELL-BEING

Based on our review of two children's case files and/or documentation from the provider, Perfect Image fully complied with six of eight elements reviewed in the area of Personal Needs/Survival and Economic Well-Being.

We noted that one child who had been placed in the home for two months had not received any clothing allowance; the child did not receive the required $50 monthly clothing allowance. The Executive Director stated that the child wanted to defer the clothing allowance to the following month in order to purchase more costly items; she acknowledged that this information was not documented in the clothing allowance log. The Executive Director stated that in the future, when a child wishes to defer the allowance, the child will sign and date an allowance agreement letter, with the information reflected in the clothing allowance log.

Additionally, both reviewed children were not encouraged and assisted in creating and updating a Life Book/Photo Album. Both of the interviewed children had no knowledge of a scrapbook or Life Book/Photo Album. The Child Care Worker stated they had taken pictures of the children during outings and were saved in the office computer. The Executive Director stated that in the future, the pictures will be downloaded, printed and given to the children. Group meetings will be conducted in order to assist the children with assembling their Life Book/Photo Albums.

Recommendations:

Perfect Image management shall ensure:

17. Children receive at least $50 per month clothing allowance or document child's preference to defer their monthly allowance to the following month.

18. All children are encouraged and assisted in creating and updating a life book/photo album.

PERSONNEL RECORDS

Based on our review of three staff files, Perfect Image fully complied with four of 14 elements in the area of Personnel Records.

We noted that two reviewed staff members did not receive a timely criminal clearance. The Facility Manager's personnel file did not contain her initial criminal clearance date, only a later clearance date of April 2008. The other reviewed staff member's (Child Care Worker) criminal clearance was not timely in that she was cleared three weeks after her hire date. Furthermore, one staff member did not complete a Criminal Background Statement, and two staff members did not receive and/or have documentation of a timely health screening. Also, all three reviewed staff files did not contain signed copies of the group home policies and procedures. In addition, the Facility Manager's personnel file did not contain documentation of the required initial training, while all three staff files had no documentation of receiving Job Shadowing training, in accordance with the Perfect Image program statement. Lastly, one staff member was not certified in CPR and First-Aid until six months after their hire date, and two staff members did not receive timely certification in the Emergency Intervention Plan. Specifically one staff member was certified 11 months after their hire date, and the other staff member was certified four months after their hire date. The Executive Director reported that the Facility Manager received a timely criminal clearance, as she was hired when the group home was licensed and could not have been licensed without the staff member being criminally cleared. The Monitor suggested they obtain from CCL documentation of the staff's initial criminal clearance date and place the documentation in the staff's file. The Executive Director stated that a designated staff member will be assigned to review staff files on a monthly basis to ensure full compliance with all regulatory agencies.

Recommendations:

Perfect Image management shall ensure:

19. All staff members receive a timely Department of Justice clearance.

20. All staff members receive a timely Federal Bureau of Investigation clearance.

21. All staff members receive a timely Child Abuse Clearance Index.

22. All staff members complete a timely Criminal Background Statement.

23. All staff members receive a timely initial health screening.

24. All staff sign copies of the Group Home policies and procedures.

25. All staff members receive the required initial training, including Job Shadow training.

26. All staff members receive timely certification in CPR.

27. All staff members receive timely certification in First-Aid.

28. All staff members receive timely certification in the Emergency Intervention Plan.

FOLLOW-UP FROM OHCMD'S PRIOR MONITORING REVIEW

Objective

Determine the status of the recommendation reported in the prior monitoring review.

Verification

We verified whether the outstanding recommendations from our prior review were implemented. The last report was issued March 30, 2012.

Results

The OHCMD's prior monitoring report contained 10 outstanding recommendations. Specifically, Perfect Image was to ensure the following: common areas are well maintained; children's bedrooms/interior are well maintained; NSPs are approved by the DCFS CSWs for implementation; NSPs are comprehensive; children are provided with opportunities to participate in YDS and vocational training programs; YDS are provided in accordance with the development of the child; all children have a current authorization for prescribed psychotropic medications; all children are encouraged and assisted in creating and maintaining Life Books/Photo Albums; all staff receive ongoing training and Emergency Intervention Plan training in accordance with Title 22 Regulations and Perfect Image's program statement.

Based on our follow-up of these recommendations, Perfect Image fully implemented three of 10 recommendations from the prior review. Perfect Image did not implement the following recommendations: common areas are well maintained; children's bedrooms/interior are well maintained; NSPs are approved by the DCFS CSWs for implementation; NSPs are comprehensive; all children have a current authorization for prescribed psychotropic medications; all children are encouraged and assisted in creating and maintaining Life Books/Photo Albums; and staff members receive the emergency intervention plan training in accordance with Title 22 Regulations and Perfect Image's program statement.

Based on the significant number of findings and failure to fully implement 70% of their CAP from the prior review is of concern and leads OHCMD to question Perfect Image's ability to maintain appropriate service delivery to our placed children; therefore, a Hold-status has been imposed on Perfect Image.

Recommendation:

Perfect Image management shall ensure:

29. Full implementation of the outstanding recommendations from the prior monitoring review, which are noted in this report as Recommendations 6, 7, 10, 11, 12, 15, 18 and 28.

MOST RECENT FISCAL REVIEW CONDUCTED BY THE AUDITOR-CONTROLLER

A fiscal review of Perfect Image has not been posted by the A-C.

The Perfect Image Youth Center
16761 Washington St
Riverside, Ca 92504
Phone (951) 776-0465
Fax (951) 776-9367

Compliance-2012

I. Licensure/ Contract Requirements

Recommendation 3 To ensure all special incidents (SIRs) are appropriately documented and cross reported timely

Status: PIYC will ensure that all areas of the SIRs are appropriately completed a staff meeting was held on July 16, 2012 with staff. All staff are to complete the SIRs on paper format and have it reviewed before it is placed on I-track. All staff is to call and write down the date, time, and names of administration, police, CSW, and Parent/ Guardian. The reports will be reviewed to ensure completion. The SIRs will then be placed on I-track and cross reported to CSW, OHCMD, and CCL in a timely manner. After the SIR is submitted and cross reported a follow up call/email will be given to CSW to ensure the SIR was received.

Plan to prevent reoccurrence: PIYC staff will be trained on appropriate documentation and timely cross reporting monthly. A refresher SIR staff training is scheduled on September 21, 2012 and will consist of completing the SIR thoroughly and cross reporting by informing CSW, CCL, OHCMD, and recording date, times, and missing person report numbers.

Person responsible for implementing corrective action: Administrator, Facility Manager

Person responsible for monitoring to ensure corrective action remains implemented and is working as intended: Administrator

Recommendation 7 PIYC is to ensure allowance logs are maintained, appropriate, and comprehensive

Status: PIYC clients will receive a weekly allowance and monthly clothing allowance as stated in program. The log will be maintained by assistant Pauleena by completing them for each client, and placing them in a book specifically for allowance and clothing allowance. PIYC will ensure allowance logs are comprehensive and appropriate by following point sheets. Before each client receives allowance staff must sign the allowance in, and the client will sign showing it was

received. All incoming and outgoing money will be recorded on the allowance log forms. If the child would like to defer the clothing allowance to the following month. The child must sign and date a letter with the date allowance was given and the deferment date. The letter will then be placed in the child's folder with allowance log.

Plan to prevent reoccurrence: PIYC will update the clients allowance logs at the end of each week. The client will then receive the designated amount according to the points. ALL allowance will be maintained, and comprehensive according to PIYC program. If a child wants to defer a weekly allowance or monthly clothing allowance. The child will sign and date a letter and it will be placed in there folder. PIYC administration will check daily and at the end of the week to ensure allowance logs are up to date.

Person responsible for implementing corrective action: Office Assistant/CCW

Person responsible for monitoring to ensure corrective action remains implemented and is working as intended: Administrator, Facility Manger

Recommendation 8 PIYC to ensure there are Community Care Licensing citations, OHCMD investigations units reports on safety and physical plant deficiencies

Status: A POC to all CCL was submitted and PIYC received a letter showing clearance. The staff will have a training on safety, physical plant, and personal rights. The A/C has been repaired and is working condition. The washer has been replaced with a new one.

Plan to prevent reoccurrence: PIYC will train the staff monthly on safety, physical plant, and personal rights. If there are any deficiencies they will be documented and action will be taken immediately by administrator and facility manager.

Persons responsible for implementing corrective action: Administrator, Facility Manager

Person responsible for monitoring to ensure corrective action remains implemented and is working as intended: Administrator

Recommendation 9 PIYC maintains a detailed sign in and out log for placed children

Status: PIYC has a created and incorporated sign in and out log for each client. The sign in and out log entails the clients name/ date/destination/time in and out, and initials (documentation attached). Each client is to complete the form before leaving and returning the facility. PIYC staff will check the sign in/out log daily to ensure it is completed before leaving and upon clients return.

Plan to prevent reoccurrence: PIYC will maintain the sign in and out logs by ensuring they are completed upon exit and return. PIYC staff and administrator will check the logs daily and

weekly to ensure they are complete.

Person responsible for implementing corrective action: Facility Manager, and Office Assistant/ CCWII

Person responsible for monitoring to ensure corrective action remains implemented and is working as intended: Administrator

II. Facility and Environment

Recommendation 10 the exterior grounds of the group home is well maintained

Status: PIYC has contacted the landlord to negotiate something about getting the front and backyard into total compliance by providing sprinklers and having grass put in. In the past and present this has been an ongoing thing with the landlord to provide grass in the yard. He has refused continuously to work with PIYC by saying we are using his house for business and the lawn is our responsibility which has caused PIYC to get sited. A message was left abd we are waiting for a return call to discuss the landscaping of the front and back yard. Due to water rationing the water company advises us to keep water use to a minimum, but we kept the weeds down by having an on duty lawn care service come though twice a month to keep the weeds down.

Plan to prevent reoccurrence: PIYC is pursuing a new location to greatly decrease deficiencies down to zero. PIYC will continue to contact and document all attempts made to the landlord in regards to the landscaping of the front and backyard. The backup plan is to partner with the landlord to complete the yard, but the rent will be raised in order to get the yard in compliance.

Person responsible for implementing corrective action: Facility Manager, and Office Assistant/ CCWII

Person responsible for monitoring to ensure corrective action remains implemented and is working as intended: Administrator

Recommendation 11 PIYC to ensure common quarters are well maintained

Status: PIYC has incorporated the recommendations on maintaining common quarters. The exposed wire in the kitchen has been repaired by a maintenance person. The wire is no longer exposed and has been remounted into the wall. The day of inspection the CEO replaced batteries in two inoperable smoke detectors. A lock has been placed on the closet where the a/c unit is located (see attachment). Carpet in front room has been replaced. Bathroom flooring has been replaced behind the toilet (see attachment). In the common areas the window sills, molding, and ceiling corners were all deep cleaned and dirty/dander has been removed.

Plan to prevent reoccurrence: Facility Manager and staff will do a monthly check with the smoke detectors to ensure they are operable. Facility Manager and staff will do a daily walk through of the facility to ensure common areas are well maintained. If anything needs to be repaired it will be logged and the maintenance person will be called immediately to ensure common quarters are maintained.

Person Responsible for implementing corrective action: Administrator, Facility Manager

Person responsible for monitoring to ensure corrective action remains implemented and is working as intended: Administrator

Recommendation 12 PIYC to ensure children's bedrooms well maintained

Status: PIYC has put in a closed light bar in the "honor room" bathroom (see attachment). The light bulbs are no longer exposed. The dressers in the bedroom had drawers that were off track. PIYC maintenance person was able to pull the drawer out and properly place it back on the track. The insufficient lighting has been resolved by placing lamps that were donated in each room to ensure the lighting is sufficient.

Plan to prevent reoccurrence: PIYC will log any maintenance that is needed in the children's bedrooms. Staff will walk through facility weekly to check for any damages. The maintenance log will be checked weekly by administrator /facility manager to ensure bedrooms are well maintained and any repairs are completed.

Person Responsible for implementing corrective action: Administrator, Facility Manager

Person responsible for monitoring to ensure corrective action remains implemented and is working as intended: Administrator

Recommendation 13 PIYC is to maintain sufficient recreational equipment in good condition and age appropriate

Status: PIYC has purchased a sufficient amount of recreational equipment for the children (see attachment). A recreational equipment inventory list has been created so that PIYC can keep track of the equipment and its condition. The equipment will be placed in the closet and checked in/out by the child. PIYC has purchased a sufficient amount of outdoor seating for the clients (picture attached). The children have stated that they don't like to go outside, but seating has been purchased and is available for all clients.

Plan to prevent reoccurrence: PIYC will check the equipment out to the children to make sure it being returned and in good condition. If the equipment isn't sufficient or damaged it will noted

and replaced in a timely manner. The outdoor equipment will be inspected weekly to ensure it is in good condition and sufficient.

Person Responsible for implementing corrective action: Administrator, Facility Manager

Person responsible for monitoring to ensure corrective action remains implemented and is working as intended: Administrator

III. Maintenance of required documentation and service delivery

Recommendation 16 The children are to be placed in accordance with the group home's population criteria

Status: The pregnant child was removed and placed in a facility for pregnant teens. Since AB12 coming into effect PIYC is no longer able to get an age waiver for the 18 year old. PIYC has submitted a revised program statement for AB12 and still is awaiting approval. Currently, no one is in the room with the 18 year old, but if a child needs to be placed with her. PIYC will receive a roommate CSW's approval to share a bedroom with adult resident. PIYC will fax and email both child and adult resident CSW to receive approval before the child is placed in the adult resident room. PIYC will also sign the approval and fax it to each CSW. The approval will then be placed in each child's folder. The facility manager and administrator will now be responsible for the admission of PIYC children and will only admit children in accordance with PIYC program statement.

Plan to prevent reoccurrence: PIYC facility manager and administrator will be the only staff responsible for admission of PIYC children and will ensure to only admit children in accordance with the PIYC program statement. The administrator and facility manager will speak with the placement person and/or CSW to ensure the child fits the criteria. PIYC will also request a copy of the child's history to be faxed over for review before the child can be placed. If the history can't be faxed for any reason. PIYC will ask the necessary questions according to PIYC program statement.

Person Responsible for implementing corrective action: Administrator, Facility Manager

Person responsible for monitoring to ensure corrective action remains implemented and is working as intended: Administrator, Facility Manager

Recommendation 17 PIYC is to obtain the DCFS CSW'S authorization to implement the needs and service plan

Status: PIYC will obtain the DCFS CSW's authorization to implement the NSP in a timely manner.

PIYC will invite the CSW a week prior to the scheduled NSP meeting by email and telephone. If the CSW is unable to attend the NSP meeting the CSW will receive a copy by email/fax within 5days requesting the CSW's signature authorizing the implementation or modification of the NSP. Documentation will be printed out and attached to the front of the NSP. The Office assistant/ CCW attended the NSP training on January 20, 2012. She held training with the LCSW, Administrator and Facility Manager to train on the new procedures in obtaining and documenting the CSW's authorizations to implement the NSP's and also the new format that will be used.

Plan to prevent reoccurrence: PIYC LCSW will ensure that the NSP's have proper authorization obtained so that the NSP may be implemented. The LCSW will call the CSW and invite them to the NSP meeting. The LCSW will document in the communication log all attempts made to the CSW. PIYC will then make a follow-up call to ensure that the CSW received the call and will be in attendance. If the CSW can't make it to the NSP meeting the office assistant will fax/email a copy requesting a signature within 5 days. All attempts will be documented and placed in front of the NSP.

Person Responsible for implementing corrective action: Office Assistant/CCW, LCSW

Person responsible for monitoring to ensure corrective action remains implemented and is working as intended: Administrator

Recommendation 22 PIYC is to ensure the treatment team develops comprehensive initial needs and service plans (NSP) with the child

Status: Upon the child's arrival to the facility the LCSW, CSW and the child will discuss the child's NSP. PIYC will ensure that the child's initial NSP is comprehensive by reviewing each section by using the template using the prompts. PIYC will ensure that the child has achievable and measurable goals.

Plan to prevent reoccurrence: PIYC LCSW will ensure that the child's NSP's are comprehensive, including case plan goals, educational and treatment plan. The LCSW, CSW, the child ad PIYC Administration will meet to develop the Childs initial needs and service plan.

Person Responsible for implementing corrective action: Administrator, LCSW

Person responsible for monitoring to ensure corrective action remains implemented and is working as intended: Administrator Sandy Cromer

Recommendations 23 PIYC to ensure children are receiving required therapeutic services

Status: PIYC LCSW will ensure that all children receive the required therapeutic group services.

All children will receive 1 group and 1 individual therapeutic service weekly. All services will be logged by the date by the therapist and placed on the NSP.

Plan to prevent reoccurrence: All the services will be noted by the LCSW to ensure that the child is receiving both individual and group therapy.

Person Responsible for implementing corrective action: Administrator, Facility Manager, LCSW

Person responsible for monitoring to ensure corrective action remains implemented and is working as intended: Administrator

Recommendation 25 PIYC to ensure DCFS CSW's are contacted monthly by Group Home and contacts are appropriately documented

Status: PIYC has created a log to document when the group home contacts DCFS CSW'S. Administration and staff is to contact DCFS CSW's monthly and record the time, date, and name of contact. The LCSW will place the monthly contact in the NSP.

Plan to prevent reoccurrence: Administration and or staff will contact DCFS CSW's monthly. PIYC will ensure that contacts are appropriately documented by writing the time, name and date on the log whenever contact is made.

Person Responsible for implementing corrective action: Administrator, Facility Manager, Office Assistant/ CCWII

Person responsible for monitoring to ensure corrective action remains implemented and is working as intended: Administrator Sandy Cromer and Facility Manager Tamika Cromer

Recommendation 28 PIYC and the treatment team is to develop comprehensive updated needs and service plans with the child

Status: PIYC will ensure that each NSP is comprehensive, including the case plan goals, educational and the treatment plan. PIYC will review the NSP with the LCSW, Administration, and the child to ensure that the goals are achievable, attainable, and maintainable. The LCSW will ensure that the NSP is updated within 30, 60, and there after every 90 days and will meet with the child, DCFS CSW and Administration to ensure goals are met. If not met the group home interventions will be documented.

Plan to prevent reoccurrence: LCSW will ensure that all NSP's are comprehensive, including case plan goals, educational and treatment plan information by reviewing each child's NSP's.

Person Responsible for implementing corrective action: Administrator, Facility Manager, LCSW

Person responsible for monitoring to ensure corrective action remains implemented and is working as intended: Administrator

IV. Psychotropic Medication

Recommendation 43 PIYC will provide a current court approved authorization for the administration of psychotropic medication for each child on psychotropic medication.

Status: PIYC will ensure that all clients PMA reflect what the child is taking and that all medications is court approved. The child's medication was discontinued which made the childs current PMA reflective and accurate of the medication she was prescribed. The child was placed back on a medication, but left the facility before the authorization could go be completed. If a child is placed with PIYC the PMA will be reviewed to ensure the current PMA reflects the actual prescribed medication.

Plan to prevent reoccurrence: PIYC will receive the child's current PMA at time of placement. PIYC designated staff will ensure that the PMA is current and medication prescribed reflects PMA.

Persons responsible for implementing corrective action: Administrator

Person responsible for monitoring to ensure corrective action remains implemented and is working as intended: Administrator

Recommendation 44 PIYC is to have a current psychotropic evaluation/ review for each child on psychotropic medication

Status: Each child taking psychotropic medication will see the psychiatrist (Samuel Dey) monthly. Each child's medication will be reviewed monthly to ensure that PMA is updated in a timely manner. The clients at PIYC that are prescribed psychotropic medication will be evaluated/ reviewed by the psychiatrist on a monthly basis and have a court approved PMA (within) every 6 months.

Plan to prevent reoccurrence: PIYC will ensure timely psychiatric reviews for children on psychotropic medication. Administrator and Office Assistant will ensure that the child's has a monthly appointment to see the psychiatrist. The Administrator and Office Assistant/ CCW will check the child's PMA to ensure the child receives evaluation/ review and has court approved PMA updated every 6 months.

Persons responsible for implementing corrective action: Administrator

Person responsible for monitoring to ensure corrective action remains implemented and is working as intended: Administrator

VII. Personal needs/ survival and economic well being

Recommendation 62 each child is receiving at least $50 per month clothing allowance

Status: PIYC will ensure that each child receives at least $50 per month for clothing allowance. The child will sign for the allowance and all clothing receipts will be placed in the child's folder with an updated clothing inventory. If the child decides to defer the $50 for the following month the child will sign and date the clothing allowance agreement letter. The clothing allowance log will reflect the amount deferred and once the amount is spent the amount will also reflect total.

Plan to prevent reoccurrence: A letter will be created signed and dated for the clients who want to defer there $50 allowance till the following month. The child's clothing will be logged on a clothing inventory with a receipt attached and placed in each child's folder.

Persons responsible for implementing corrective action: Facility Manager, Office Assistant/ CCWII

Person responsible for monitoring to ensure corrective action remains implemented and is working as intended: Administrator

Recommendation 69 PIYC is to ensure that all children are encouraged and assisted in maintaining photo albums/life books

Status: All children will be assisted and encouraged to make a photo album/ life from the time they are placed at PIYC. Outing the photo's are uploaded on the computer and printed out and given to the children. The day after the outing the staff and clients will have a group project to put the albums/life books together with pictures, stubs from events, and any other momentums. The children choose not to place them in a book. Instead, the place them on their bedroom walls or place them on social networks (they ask to place them on social networks). All pictures are kept on PIYC computer. The children choose to use their own devices (iPod, cell phone, and all other devices that allow you to take pictures) to take pictures while on outings, but PIYC still uses a digital camera to ensure photo's are being taken. A letter has been created for the children who wish to opt out of taking photos.

Plan to prevent reoccurrence: A letter will be created signed and dated for the clients who

choose not to be in photos. A copy of the photo's will be printed out and given to the children to place in their life book or on their walls. A photo album will be given to each child so that all pictures can be placed from the outings into it. If the child wishes to opt out of photos. The child will still sit with the group and place other memorabilia such as ticket stubs, flyers, ect. into life book/ photo albums

Persons responsible for implementing corrective action: Facility Manager, Office Assistant/ CCWII

Person responsible for monitoring to ensure corrective action remains implemented and is working as intended: Administrator

X. Personnel Records

Recommendation 73,74,75 PIYC to ensure that DOJ, FBI, and Child Abuse Index Clearance are submitted timely

Status: PIYC has incorporated the submitting DOJ, FBI, and Child Abuse clearance for new hires. Before a new hire can began working at PIYC they must be cleared by getting a life scan from licesnsing. After PIYC receives the clearance's for new hires the paperwork will be placed in the staff's files immediately. TC has been cleared since 2004. She has received a copy of her DOJ (See attachment).

Plan to prevent reoccurrence: A new hire must have a FBI clearance, child abuse index clearance before beginning work at PIYC. PIYC will ensure that each employee has a life scan and the clearance is in each employee file.

Persons responsible for implementing corrective action: Administrator, Office Assistant/CCW

Person responsible for monitoring to ensure corrective action remains implemented and is working as intended: Administrator

Recommendation 76, 78, 80 PIYC is will ensure employees have signed copies of the criminal background statement, health screening, and the group home policies and procedures

Status: All new hires will receive the required paperwork criminal background statement, health screening, and the group home policy and procedures. Each employee will sign and date the paperwork and the original will be placed in there employee file upon hire and a copy will

be given to the employee. All forms and documents will be submitted prior to staff being hired.

Plan to prevent reoccurrence: PIYC will make sure all employees sign and date there criminal background statement, and the group home policy and procedures. A completed health screen will be needed before the employee begins to ensure they are able to work. A copy of all paperwork will be given to the employee and the original placed in there employee file on the day of completion. PIYC will have all completed forms and documents prior to the staff member being hired.

Persons responsible for implementing corrective action: Facility Manager, Office assistant/CCWII

Person responsible for monitoring to ensure corrective action remains implemented and is working as intended: Administrator

Recommendation 81 PIYC will ensure that all employees receive required initial training

Status: All new hires will receive the required 24 hours training including shadowing which is comprised of the 8 and 16 hours. All training will be logged and placed in staff personnel files.

Plan to prevent reoccurrence: PIYC will make sure to log all training that is given to be employees. New hires initial training will be logged and signed off and placed in their employee file

Persons responsible for implementing corrective action: Facility Manager

Person responsible for monitoring to ensure corrective action remains implemented and is working as intended: Administrator

Recommendation 83 and 84 PIYC will receive CPR Training and First-Aid training

Status: PIYC has provided CPR and First-Aid training from an outside licensed trainer for all employees. A copy of the employee CPR card will be placed in employee file.

Plan to prevent reoccurrence: PIYC administration will ensure that all employees CPR and First-Aid is up to date by checking each employees files monthly. The employee will be notified a month prior to CPR & first aid to ensure it is renewed in a timely manner.

Persons responsible for implementing corrective action: Facility Manager, Office Assistant/ CCWII

Person responsible for monitoring to ensure corrective action remains implemented and is working as intended: Administrator

Recommendation 86 PIYC Employees will receive Emergency Intervention Training per group home program statement

Status: PIYC has provided emergency intervention Training with a certified trainer in Crisis Prevention Intervention (CPI). A refresher course will be given once a year and review once a month during staff meetings/ trainings.

Plan to prevent reoccurrence: Administration and office assistant will ensure all staff training and certificates are current by reviewing staff folders on a monthly basis and document progress. Copies of all certificates and signed in sheets will be maintained in staff files.

Persons responsible for implementing corrective action: Administrator, Facility Manager

Person responsible for monitoring to ensure corrective action remains implemented and is working as intended: Administrator

PIYC will ensure compliance and the requested documents by following title 22. PIYC will review the facility checklist as needed daily, weekly and monthly to ensure PIYC is in compliance and have requested documents. The persons responsible for the CAP are the Administrator, Facility Manger and Office Assistant for implementing and maintain the CAP.

Sandy Crone

Administrator

9/17/12

Date